

ATTENDING DENTIST'S STATEMENT

CHECK ONE:
 DENTIST'S PRE-TREATMENT ESTIMATE
 DENTIST'S STATEMENT OF ACTUAL SERVICES

Physicians' Benefits Trust
 P.O. Box 909786-60690
 Chicago, IL 60690

| | | | | | | |
|------------------------|---|--|--|---|--|--|
| PATIENT SECTION | 1. Patient Name First M.I. Last | 2. Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ | 3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | 4. Patient Birthdate MM DD YYYY | 5. If Full Time Student School City | |
| | 6. Insured/Subscriber Name and Mailing Address | | 7. Insured/Subscriber Birthdate MM DD YYYY | 8. Group No. | | |
| | 9. Is Patient Covered by Another Plan of Benefits? Medical _____ Dental _____ | 10-A. Name and Address of Carrier(s) | 10-B. Group Number(s) | 11. Name and Address of Employer | | |
| | 12-A. Insured/Subscriber Name (if different than Patient's) | | 12-C. Insured/Subscriber Birthdate | 13. Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ | | |

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME

SIGNED (INSURED PERSON) _____ DATE _____

| | | | | | | |
|------------------------|--|--|--|------------------------------------|--------------------------------------|-------------------------------|
| DENTIST SECTION | 14. Dentist Name | 23. Is Treatment Result of Occupational Illness or Injury? | No | Yes | If Yes, Enter Brief Description | |
| | 15. Mailing Address | 24. Is Treatment Result of Auto Accident? | | | | |
| | 16. City, State, Zip | 25. Other Accident | | | If no, reason for replacement | |
| | 17. Dentist SSN or TIN 18. Dentist License No. 19. Dentist Phone No. | 26. Are any services covered by another plan? | | | | 29. Date of Prior Replacement |
| | 20. First Date of Current Series | 21. Place of Treatment Office Hosp. ECF Other | 22. Radiographs of Models Enclosed? How Many? | 28. Is Treatment For Orthodontics? | If Services Already Commenced Enter: | Date Appliances Placed |

Identify Missing Teeth with "X"

32. Remarks for Unusual Services

| 31. Examination and Treatment Plan - List In Order from Tooth 1 thru Tooth 31-Use Charting System Below | | | | | | |
|---|---------|---|------------------------|------------------|-----|--------------------|
| Tooth # or Letter | Surface | Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No. | Date Service Performed | Procedure Number | Fee | For Admin Use Only |
| | | 1 | | | | |
| | | 2 | | | | |
| | | 3 | | | | |
| | | 4 | | | | |
| | | 5 | | | | |
| | | 6 | | | | |
| | | 7 | | | | |
| | | 8 | | | | |
| | | 9 | | | | |
| | | 10 | | | | |
| | | 11 | | | | |
| | | 12 | | | | |
| | | 13 | | | | |
| | | 14 | | | | |
| | | 15 | | | | |

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THESE PROCEDURES.

DATE _____
 SIGNED (DENTIST) _____

| | |
|--------------------------|--|
| TOTAL FEE CHARGED | |
| Max. Allowable | |
| Deductible | |
| Carrier % | |
| Carrier Pays | |
| Patient Pays | |

***Please do not submit x-rays unless specifically requested**